Barnsley Hospital NHS
NHS Foundation Trust

Learning from Deaths Policy

Document Control

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Distribution:

Barnsley Hospital NHS Foundation Trust Policy Website.

Please note that the Policy Website version of this document is the only version that is maintained.

Any printed copies must therefore be viewed as “uncontrolled” and as such, may not necessarily contain the latest updates and amendments.

Contents

1 Introduction

Patient safety and scrutiny of mortality rates has intensified with investigations into NHS hospital failures leading to publication of the Keogh (2013) and Frances (2013) reports. It is essential that Barnsley Hospital NHS Trust Board have assurance that when patients have died in hospital the quality of care the patient received was in accordance with current good practice.

Measures of mortality such as Summary Hospital-level Mortality Indicator (SHIMI) and Hospital Standardised Mortality Ratio (HSMR) can be used as a useful indicator of mortality trends. These statistically modelled indicators provide information on deaths within certain clinical groups. If the actual number of deaths differs from the expected number of deaths, or the numbers move outside of the set confidence limits, it can trigger organisations to look at deaths in more detail.

The mortality indicator statistics used within Barnsley Hospital NHS Trust are:

- Hospital Standardised Mortality Ratio (HSMR). The HSMR is calculated each month for each hospital in England. It looks at deaths in the most common conditions in hospital which account for around 85% of deaths in hospital.
- Summary Hospital-level Mortality Indicator (SHMI). The SHMI score looks at all deaths in hospital and within 30 days of discharge from hospital
- Crude Mortality data. The number of monthly recorded deaths

Mortality statistics do not in themselves give evidence on the standard of care provided. This can be ascertained by reviewing the care episode of a patient who has died to identify any preventable factors that may have influenced the likelihood of death. Findings and learning from the mortality reviews can be used to make appropriate improvements to patient care. As well as ensuring there are surveillance processes in place within the Trust to promptly and accurately record deaths, and to interrogate and understand mortality indicators, it is also important to ensure that

there are independent clinical reviews of deaths within the Trust to accommodate the complexity of modern healthcare.

Nationally there has been a recent review of learning from deaths and both the Care Quality Commission (CQC) and NHS Improvement (NHSI) have published guidance (applicable to adult patients) on learning from deaths. A new formalised process addresses the CQC's publication (2016) on the way NHS Trusts review and investigate the deaths of patients, and this aims to maximise learning from deaths.

The Trust Mortality Review Process (MRP) has therefore been aligned to the National Mortality Case Record Review (NMCRR) Programme, which is a collaborative project led by the Royal College of Physicians (RCP) in partnership with Yorkshire and Humber Academic Health Science Network's (AHSN's) Improvement Academy. It is commissioned by the Health Quality Improvement Partnership (HQIP). The NMCRR programme introduced a standardised methodology for reviewing case records of adult patients who have died in acute general hospitals in England and Scotland, known as the Structured Judgement Review (SJR). Deaths are screened to ascertain if a more in depth review is required and the SJR method ensures a consistent and coordinated approach for the in depth review of deaths in hospital.

The Department of Health has announced the introduction of Medical Examiners from April 2018 to "independently review and confirm cause of death". This is a national extension of the initial programme which began in 2005 following the Shipman Enquiry. Subsequent enquiries including the Francis Report into Mid Staffs (2013) and the Kirkup report on Morecambe Bay in 2015(1) found that the role of medical examiner could have played a vital role as a conduit for relatives concerns(2).

Medical examiners will be part of a national network of specifically trained independent senior doctors (from any specialty).

Overseen by a National Medical Examiner, the emphasis of the role will be to scrutinise all deaths across a local area that do not fall under the coroner's jurisdiction.

However, it is expected that such posts will have close liaison with the Coroner's office. The Medical Examiner Role is separate from the Structure Judgement Review process (SJR). Reform was required because the process of death certification has changed very little in nearly 150 years.

The certification of death is usually delegated to junior doctors and is often not done well. There is evidence that up to ten per-cent of death certificates are completed to a poor standard and just over half (55%) could be improved. A recent study by the Office for National Statistics found that if the death certificate is checked by a Medical examiner, the underlying cause of death is recorded differently in 22% of cases.

If there is any suspicion that 'unnatural causes' (such as accident, neglect, industrial disease, self-harm or link to a medical procedure) may have contributed to a death, or if the cause of death is unknown, the death must be reported to the coroner as currently happens, who may investigate and hold an inquest.

2 Objective

This policy recognises the need to consider mortality rates and national mortality indicators using information available at individual patient level. The objective is to review whether the quality of care the patient received was in accordance with current good practice and to identify any areas that could potentially be improved, based upon either the screening process or the in depth review. Areas of good practice can also be identified and used to improve care.

In summary the objective is to:

- Identify and minimise poor quality care as identified in the Medical Examiners (ME) scrutiny or in the SJR data sheet.
- Use learning to improve the experience of patients, their families and carers and clinical quality.

3. Scope of Policy

The National Guidance on Learning from Deaths (2017) makes recommendations on which cases should be reviewed but does not suggest that all deaths require a SJR. A ME Scrutiny process is undertaken on all deaths with a view to selecting those that may require a more in depth SJR.

At BHNFT a Consultant led ME scrutiny takes place on all adult deaths Deaths that are already subject to scrutiny from other processes, will continue to take place such as:

- coroners case
- inquest
- serious incident (SI) investigation relating to the death or same patient episode
- complaint investigation relating to the death or same patient episode
- Venous thromboembolism (VTE) root cause analysis (RCA) relating to the death of the patient
- Deaths of those with learning disabilities are subject to a separate review as detailed in Appendix 2.
- Deaths of patients under the age of 18 years, maternal deaths and stillbirths are subject to separate review processes

The following criteria is used to inform selection of cases for a more in depth Structured Judgement Review (SJR) and therefore provides the scope of this policy. This list is however not exhaustive:

- Death where the ME scrutiny has raised a concern.
- Deaths of those identified with a severe mental illness (as defined by the Royal College of Psychiatrists)
- Deaths where the ME has identified a lack of compliance with policy which may have led to poor care.
- Deaths where the ME scrutiny has identified a lack of compliance with current good practice which may have led to poor care.

- Deaths of those who are identified in the ME scrutiny to be significantly disadvantaged in some way.
- Deaths subject to scrutiny from other processes may still have an SJR if further aspects of care need review.

A further sample of other deaths may be selected that do not fit the identified categories, for example to take learning from where excellent care has been delivered or where changes in the delivery of a care pathway could be improved.

Occasionally deaths may not be selected that do fit the criteria if it is already known that the concern raised by the reviewer is being (or recently has been) addressed in another group or process

3.1 Staff groups

Who will be involved in the process include (list is not exhaustive):

- Medical Staff (all grades)
- Nursing Staff
- Clinical Coding Staff
- Clinical Audit & Effectiveness Staff
- Information Analysts
- Patient Safety & Quality Improvement team
- Medical secretaries (for case note tracking and return)
- Medical Examiners
- Medical Examiners Officers

3.2 Process

Attach process form, rather than below

- The Bereavement Office supplies a weekly list of deaths
- Clinical Coding collect notes from the general office and post coding place the notes on the mortality shelf for the following Mortality Overview Group.
- Completed ME Scrutiny are reviewed by the Mortality Overview Group
- Quantitative and qualitative data from the ME Scrutiny forms are recorded on the MEO Action Log.

- The Mortality overview group allocate any SJR's required as suggested by the ME Scrutiny form in Section 3 of this policy.
- Mortality Tracking Spread sheet filled in with ME Scrutiny completion dates and whether further escalation is required e.g
- The Medical Examiners Officer or Patient Safety will distribute notes for further investigation to the SJR panel.
- Where the Mortality Overview Group indicates an SJR is required, it will be conducted in line with the Royal College of Physicians documentation.
- Case notes for SJR will be reviewed by the SJR Panel who are individuals trained in the SJR process. The expected time to complete a SJR is about 2 hours and turnaround 20 days.
- Quantitative and qualitative data from the SJR data forms are recorded on the mortality database
- If any structured judgement reviewer has difficulty in deciding what level to rate the care, or if on review the findings are that there were episodes of poor care, the AMD may support, or further escalation to Patient Safety Panel.
- ME Scrutiny forms and SJR data forms are screened and stored electronically to create a library of mortality information.

4 Sharing Learning

Qualitative data from the ME scrutiny and SJR forms is collated and learning is shared via the learning from deaths bulletin. Individual feedback is given by letter, email or in person by the AMD where appropriate.

Learning can also be reported via clinical governance meetings by the CBU representatives who attend the Learning from Mortality Group, where appropriate actions to improve speciality care are generated and managed. Other relevant platforms to share learning are utilised as appropriate.

Discussions, outcomes and learning from the Learning from Mortality group, including any conclusions about good or outstanding care and sub-optimal care, are formally recorded in a chairs log report using the Trust Governance Structure via the Clinical Effectiveness Group.

Themes of learning and good practice will be shared in a monthly mortality report via the governance structure and through Board reports which will be produced quarterly. This will include the HSMI and SHMI dash board and qualitative learning themes.

4.1 Escalation

BHNFT have a SJR panel, this panel consists of 5 anaesthetic/intensivists, who complete the SJR's. If an SJR identifies 3 or more episodes of poor care (out of the 5 SJR episodes and excluding overall care), the AMD will review the SJR, seek further clarity if needed and if appropriate present an escalation to the patient safety panel with recommendations for review and decision.

If a High level Investigation or Serious Incident is commenced as a result of the findings in an SJR, the SI process supersedes the SJR. The Duty of Candour Policy should also be followed as part of any further investigation process.

5 Mortality Alerts

If there are concerns about mortality in any particular patient group, for example a higher than expected HSMR for a particular diagnostic group, it may be necessary to undertake an in-depth review for assurance.

The review will follow the methodological order for investigation of a high HSMR which is check coding, review case-mix and review care.

Any in depth reviews in any particular patient group that may be of concern must be reported to the Medical Director or in their absence to the Deputy Medical Director and reported to the Clinical Effectiveness group

A list of patients within the relevant diagnostic group will be produced by Information analyst for the speciality team to review. This may also be shared with clinical coding to check for coding accuracy.

A review of the patients relevant to the alert will take place by the speciality with support from the Associate Medical Director (AMD) for Mortality who will then determine the way forward for a multi-disciplinary review team to be set up.

Once this review has been completed and a report is produced it should be shared within the Trust through the governance structure (Clinical Effectiveness Group).

The report should be constructed demonstrating methodology, findings, learning and recommendations.

6 Roles and Responsibilities

6.1 Trust Board Executive and Non – Executive Directors

The Board of Directors must be assured that robust systems are in place for recognising, reporting, reviewing or investigating deaths and learning from avoidable deaths that are contributed to by lapses in care. The roles and responsibility of the Trust board includes

- Understanding the Mortality Review process
- Ensuring it can withstand external scrutiny
- Champion and supports learning and quality improvements
- Assure published information is fair and accurate
- Appoint a designated Non-Executive Director to attend the Learning from Mortality Group meetings.

6.2 Medical Director

The Medical Director is the Lead Executive for Mortality Review within the Trust and will ensure that appropriate processes are in place to review mortality data and learning. This will be monitored through the Trust Governance Structure. The reporting outcomes and findings from the Mortality Review Group will go to the Trust Board via the Trust Governance Structure. If the Medical Director is absent the Deputy Medical Director will deputise.

6.3 Deputy Medical Director

The Deputy Medical Director will deputise as the Lead Executive in the absence of the Medical Director for Mortality Review within the Trust and as such will adopt the same responsibilities as the Medical Director.

6.4 Associate Medical Director for Mortality

The Associate Medical Director will be responsible for:

- Overall oversight and regular review of the mortality peer review process
- Ensuring and supporting the structured judgement review method is used, utilising the SJR panel
- Ensuring training is available for staff to complete structured judgement reviews.
- Ensuring any speciality mortality statistics are included in the CBU governance packs for discussion at CBU level.
- Initiating any speciality wide reviews in response to mortality indicators or themes from the mortality process

6.5 Head of Patient Safety and Quality Improvement

Head of Patient Safety and Quality Improvement will be responsible for:

- Supporting the Associate Medical Director and the Medical Examiner Service with ensuring that ME Scrutiny's, SJR's and Learning and feedback from deaths takes place
- Ensuring links with the regional groups are maintained and new developments reported to the Learning from Mortality group.
- Supports the AMD with compilation of the Learning from Deaths bulletin and the monthly report to Quality & Governance

6.6 Patient Safety Team

The Patient Safety Team will be responsible for:

- Overseeing the process of the mortality overview group action log
- Overseeing the mortality tracker and identifying any issues to the AMD
- Providing apprentice level support to the Information analyst with data inputting and adding ME Scrutiny and SJR forms to the mortality library during periods of conflicting priorities, leave or absence

6.7 Consultants

Consultants are responsible for participating in mortality case note reviews at either the request of the Medical Examiner or the Associate Medical Director for Mortality. This may be to review points of patients in their care or to give a specialist opinion on areas such as:

- Timely consultant/medical reviews
- Communication with families and/or carers
- Use of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)
- Timely escalations or referrals
- Any non compliance with trust wide policies (for example VTE assessment and Sepsis screening)

- Any learning from good or excellent care
- The use of Mycareplan
- Clarification on specific points from either the ME service or from the SJR panel

6.8 Medical Examiners Service

Medical examiner offices at acute trusts are staffed by a team of medical examiners, supported by medical examiner officers. Medical examiners are senior medical doctors who are contracted for a number of sessions a week to undertake medical examiner duties, outside of their usual clinical duties. They are trained in the legal and clinical elements of death certification processes.

The role of these offices is to examine deaths to:

- agree the proposed cause of death and the overall accuracy of the medical certificate cause of death
- discuss the cause of death with the next of kin/informant and establishing if they have any concerns with care that could have impacted/led to death
- act as a medical advice resource for the local coroner
- inform the selection of cases for further review under local mortality arrangements and contributing to other clinical governance procedures.
- The medical examiners officer will attend the weekly MOG meeting, to provide a weekly update for escalation of actions if required.

6.9 Other Medical and Nursing Staff

Will be responsible for:

- Checking coding accuracy against patient episodes when requested
- Giving specialist opinions
- Participating in the mortality process wherever possible, either in person or by nominated staff being available for advice on medical and nursing issues

6.10 Clinical Coding Staff

Clinical Coding staff will be responsible for:

- Participating in the mortality overview group meetings and the learning from deaths group
- Ensuring episodes of care as identified in the screening process are accurately coded.
- Issues arising from the reviews regarding clinical coding should be addressed directly with the clinician concerned by the head of coding to promote learning and improvement

6.11 Information Analyst (Management Information)

The Information Analyst will be responsible for:

- The maintenance of a quantitative and qualitative database from derived from mortality information
- Timely production of mortality statistics and learning from deaths reports for the AMD and Head of PSQI
- Provide other related reports as required by the AMD and Head of PSQI
- Maintain and produce mortality dashboards
- Issue compliance figures on screening returns and SJR returns
- Act as liaison between BHNFT and the external health informatics team regarding mortality statistics

6.12 Bereavement Office

The bereavement officer is responsible for

- Sending a list of Trust deaths to the Associate Medical Director (Mortality), Clinical Coding, Governance and Clinical Audit & Effectiveness which will include inpatient PAS/EHR information
- Providing written information to relatives or carers via the bereavement booklet

6.13 Clinical Audit & Effectiveness Team

The Clinical Audit & Effectiveness Team will be responsible for:

- Supporting any audits that arise from the mortality review process
- Feeding back the reports and outcomes to the clinical leads for each area

6.14 Mortality Overview Group

The Mortality Overview Group will

- comprise of – Information Analyst, Clinical Coding, Head of Patient Safety and Quality Improvement (or delegated deputy) and Associate Medical Director (or delegated deputy) medical examiners officer with support from the patient safety team
- Raise any issues in coding with the head of coding (used to identify co-morbidities and expected deaths).
- Allocate SJR's
- meet weekly and review the recommendations from the medical examiners scrutiny and completed SJR's in accordance with this policy.
- Allocate SJR's where required to the SJR panel
- Request specialist information if needed from clinical leads
- Complete any escalations to the Patient Safety Panel
- Agree and approve the Medical examiners e-forms ~~a~~nd make changes as required
- Identify any training needs within the mortality process that become apparent from reviewing returned ME Scrutiny and/or SJR forms
- The group will feed into the Learning from Mortality Steering Group.

6.15 Learning from Mortality Group

The Learning from Mortality Group will be responsible for:

- Providing assurance to the Trust Board via the Trust Governance Structure on patient mortality based on mortality statistics and findings from ME Scrutiny and SJR's
- Identifying areas of high risk and escalating these to the CBU through the CBU representatives
- Ensuring the CBU's are aware of any alerting groups via the HSMR section in the CBU information packs
- Ensuring that feedback and learning points are shared with the trust and specialties via the group so that learning outcomes and action points are included in specialty audit programmes as appropriate
- The group report to the Trust Governance Structure through the Clinical Effectiveness Group

7 Associated documentation and references

- NHS Improvement (2019) The National Medical Examiner System
- Francis R (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. London: The Stationery Office. London: Department of Health.
- Keogh B (2013) Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report. London: NHS England.
- NHS England, Mortality Governance Guide
- Morbidity & Mortality Meetings: A guide to good practice, Royal College of Surgeons (2015)
- Care Quality Commission (December 2016), Learning, candour and accountability: a review of the way NHS trusts review and investigate the deaths of patients in England
- Higginson J, Walters R, Fulop N, *BMJ Qual Saf (2012)*, Mortality and morbidity meetings: an untapped resource for improving the governance of patient safety?

- National Guidance on Learning from Deaths, National Quality Board (March 2017)

7.1 Training & Resources

- In order for Structured Judgement Reviews to be completed the SJR Panel reviewers must have undertaken the formal training.
- Dedicated on-going trainers must be available to ensure consistency
- Training will be recorded on the NMLS data base.
- The Associate Medical Director has to have job planning that reflects their mortality review role.
- Time allocation for those supporting the process to carry out relevant duties
- Support for the movement of medical records across the organisation
- Medical Examiners and Medical Examiners Officer training consists of a full day face to face training provided by the Royal College of Pathologists and e-learning modules

7.2 Monitoring and Audit

Minimum requirement to be monitored	Compliance of ME scrutiny and SJR
Process for monitoring e.g. audit	Data collection on completed scrutiny's and SJR's where applicable Audit
Responsible individual/ group/ committee	Medical Examiners Officer/Patient Safety Team/Management information team
Frequency of monitoring	Monthly
Responsible individual/ group/ committee for review of results	Learning from Mortality Steering Group
Responsible individual/ group/ committee for development of action plan	Learning from Mortality Steering Group
Responsible individual/group/ committee for monitoring of action plan and Implementation	Learning from Mortality Steering Group

8 Equality and Diversity

Trust is committed to an environment that promotes equality and embraces diversity in its performance as an employer and service provider. It will adhere to legal and performance requirements and will mainstream equality and diversity principles through its policies, procedures and processes. This policy should be implemented with due regard to this commitment.

To ensure that the implementation of this policy does not have an adverse impact in response to the requirements of the Equality Act 2010 this policy has been screened for relevance during the policy development process and a full equality impact analysis conducted where necessary prior to consultation. The Trust will take remedial action when necessary to address any unexpected or unwarranted disparities and monitor practice to ensure that this policy is fairly implemented.

This policy and procedure can be made available in alternative formats on request including large print, Braille, moon, audio, and different languages. To arrange this please refer to the Trust translation and interpretation policy in the first instance.

The Trust will endeavor to make reasonable adjustments to accommodate any employee/patient with particular equality and diversity requirements in implementing this policy and procedure. This may include accessibility of meeting/appointment venues, providing translation, arranging an interpreter to attend appointments/meetings, extending policy timeframes to enable translation to be undertaken, or assistance with formulating any written statements.

8.1 Recording and Monitoring of Equality & Diversity

The Trust understands the business case for equality and diversity and will make sure that this is translated into practice. Accordingly, all policies and procedures will be monitored to ensure their effectiveness.

Monitoring information will be collated, analysed and published on an annual basis as part Equality Delivery System. The monitoring will cover the nine protected characteristics and will meet statutory duties under the Equality Act 2010. Where adverse impact is identified through the monitoring process the Trust will investigate and take corrective action to mitigate and prevent any negative impact.

The information collected for monitoring and reporting purposes will be treated as confidential and it will not be used for any other purpose.

Appendix 1

EQUALITY IMPACT ASSESSMENT TEMPLATE

INITIAL ASSESSMENT STAGE 1 (part 1)

Department:	Quality / Governance	**Division:**	Corporate
Title of Person(s) completing this form:	Deborah Firth	**New or Existing Policy/Service**	New
Title of Policy/Service/Strategy being assessed:	Policy for the Review of Clinical Care following the death of a patient in Hospital	**Implementation Date:**	September 2017
What is the main purpose (aims/objectives) of this policy/service?	The Structured Judgement Review (SJR) ensures a consistent and coordinated approach for the review of all deaths in hospital. This policy recognises the need to consider mortality rates and national mortality indicators available at diagnosis and individual patient level. That all preventable deaths are identified and patient safety improved		

Will patients, carers, the public or staff be affected by this service? Please tick as appropriate.		Yes	No	If staff, how many individuals/which groups of staff are likely to be affected?
	Patients	x		
	Carers		x	
	Public		x	
	Staff		x	
Have patients, carers, the public or staff been involved in the development of this service? Please tick as appropriate.	Patients		x	If yes, who did you engage with? Please state below: Consultation of the mortality Committee
	Carers		x	
	Public		x	
	Staff	x		
What consultation method(s) did you use?	Staff review at relevant meetings			

DATA COLLECTION AND CONSULTATION

1a In relation to this service/policy/procedure – Do you currently record/have any of the following patient data?

Protected Characteristic	Indicate yes or No	If Yes – State where Recorded
Age	**YES**	**On the screening tool**
Sex	**YES**	**On the screening tool**
Ethnicity	**NO**	
Religion or Belief	**NO**	
Disability	**YES**	**On the screening tool**
Sexual Orientation	**NO**	
Gender Re-assignment	**NO**	
Marriage & Civil Partnership	**NO**	

Pregnancy & Maternity	**Yes**	**On the screening tool**
Carer Status	**NO**	

Please indicate Yes or No

Equality Impact Assessment Stage 1 PART 2
What does this data tell you about each of the above protected characteristics? Are there any trends/inequalities?

No inequalities – the screening tool is used to ensure deaths are reviewed correctly

What other evidence have you considered? Such as a 'Process Map' of your service (assessment of patient's journey through service) / analysis of complaints/ analysis of patient satisfaction surveys and feedback from focus groups/consultations/national & local statistics and audits etc.

National Guidance from the National Quality Board

Equality Impact Assessment Stage 1 PART 3

ACCESS TO SERVICES

What are your standard methods of communication with service users?

Please tick as appropriate.

Communication Methods	Yes	No
Face to Face Verbal Communication		x
Telephone		x
Printed Information (E.g. leaflets/posters)		x
Written Correspondence		x
E-mail		x
Other (Please specify)	X we may need to communicate with relatives or carers	

If you provide written correspondence is a statement included at the bottom of the letter acknowledging that other formats can be made available on request?

Please tick as appropriate.

Yes	No
	x

Are your staff aware how to access Interpreter and translation services?

Interpreter & Translation Services	Yes	No
Telephone Interpreters (Other Languages)	x	
Face to Face Interpreters (Other Languages)	x	
British Sign Language Interpreters	x	
Information/Letters translated into audio/braille/larger print/other languages?	x	

ACCESS

Please tick as appropriate

Is the building where the service is located wheelchair accessible?	Yes	No
Does the reception area have a hearing loop system?	x	
Does the building where the service is located have a unisex wheelchair accessible 'disabled toilet?	x	
Does the building have car parking space reserved for Blue Badge holders?	x	
Does the building have any additional facilities for disabled people such as a wheelchair, hoist, specialist bath etc?	x	
Does the building/hospital sire where the service is provided have access to prayer and faith resources?	x	

EQUALITY IMPACT ASSESSMENT – STAGE 1 (PART 4)

Protected Characteristic	Positive Impact High	Negative Impact High	Reason/comments for positive Impact Why it could benefit any/all of the	Reason/Comments for Negative Impact Why it could disadvantage any/all of the protected	Resource Implication Yes / No

	Low None	Low None	protected characteristics	characteristics	
Men	**Low**				**Staff to complete the reviews**
Women	**Low**				
Younger People (17 – 25) and Children	**Low**				
Older people (60+)	**Low**				
Race or Ethnicity	**Low**				
Learning Disabilities	**Low**				
Hearing impairment	**Low**			.	
Visual impairment	**Low**				
Physical Disability	**Low**				
Mental Health Need	**Low**				
Gay/Lesbian/Bi sexual	**Low**				
Trans	**Low**				
Faith Groups (please specify)	**Low**				
Marriage & Civil Partnership	**Low**				
Pregnancy & Maternity	**Low**				
Carer Status	**Low**				
Other Group (please specify)					
Applies to ALL Groups	**Low**				

INITIAL ASSESSMENT (PART 5)

Have you identified any issues that you consider could have an adverse (negative) impact on people from the following protected groups?

IF 'NO IMPACT' IS IDENTIFIED Action: No further documentation is required.

IF 'HIGH YES IMPACT' IS IDENTIFIED Action: Full Equality Impact Assessment Stage 2 Form must be completed.

(a) In relation to each group, are there any areas where you are unsure about the impact and more information is needed?

(b) How are you going to gather this information?

Title of Service/Policy being assessed:	
Assessment Date:	
Is the service/policy aimed at a specific group of users?	

(c) Following completion of the Stage 1 Assessment, is Stage 2 (a Full Assessment) necessary? NO

Assessment Completed By: Deborah Firth **Date Completed:** 30/08/2017
Reassessed: 13/03/2019
Reassessed: 18/03/2020

Line Manager Tracey Radnall Date…18/03/2020

Head of Department Tracey Radnall Date…13/03/2020

When is the next review? Please note review should be immediately on any amendments to your policy/procedure/strategy/service.

1 Year	**2 year**	**3Year**

STAGE 2 – FULL ASSESSMENT & IMPROVEMENT PLAN
MUST be completed if any negative issues have been identified at stage 1

Protected Characteristic	**What adverse (negative) impacts were identified in Stage 1 and which groups were affected?**	**What changes or actions do you recommend to improve the service to eradicate or minimise the negative impacts on the specific groups identified?**	**Lead**	**Time-scale**
Men Younger People (17-25) and Children Older People (50+) Race or Ethnicity Learning Disability				

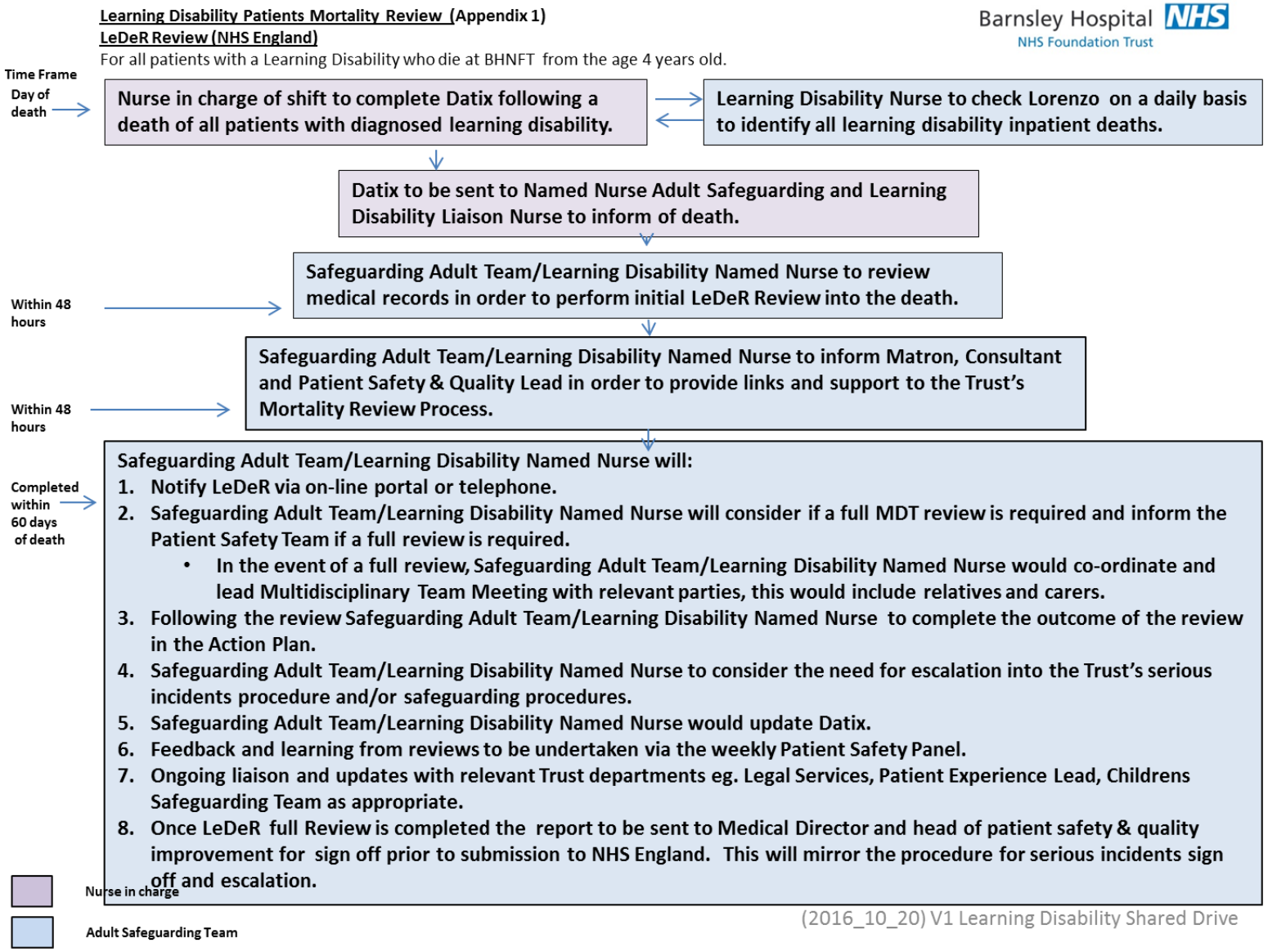
Hearing Impairment Visual Impairment Physical Disability Mental Health Need Gay/Lesbian/Bisexual Transgender Faith Groups (please specify) Marriage & Civil Partnership Pregnancy & Maternity Carers Other Group (please specify) Applies to ALL Groups				
How will actions and proposals be monitored to ensure their success? Which Committee will you report to? (i.e. Divisional DQEC / Governance Meeting).				
Who will be responsible for monitoring these actions?				

Appendix 2

Glossary of Terms used within Policy

Term	Meaning
(SHIMI)	Summary Hospital-level Mortality Indicator – A Mortality Indicator based on the analysis of deaths of patient in hospital and up to 30 days post discharge.
(HSMR)	Hospital Standardised Mortality Ratio – A Mortality Indicator based on the analysis of deaths of patient in hospital
(NHSI)	NHS Improvement (NHSI) is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care.
(VTE)	Venous thromboembolism (VTE) is a condition in which a blood clot forms most often in the deep veins of the leg, groin or arm (known as deep vein thrombosis, DVT) and travels in the circulation, lodging in the lungs (known as pulmonary embolism, PE).
RCA	Root cause analysis (RCA) is a structured method used to analyse serious adverse events.
SI	The Serious Incident framework describes the process and procedures to help ensure serious incidents are identified correctly, investigated thoroughly and, most importantly, learned from to prevent the likelihood of similar incidents happening again. DNACPR
“Do Not Attempt Cardiopulmonary Resuscitation” DNACPR	A DNACPR decision is a decision made in advance that attempted CPR would not be likely to be appropriate for a person in the event of cardiac arrest.
Sepsis	Sepsis is a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs.
Sepsis Screening	A screening tool for sepsis is a methodology used to identify sepsis early and lead to more timely diagnostics and treatment.

Appendix 3


Learning Disability Patients Mortality Review (Appendix 1)
LeDeR Review (NHS England)
For all patients with a Learning Disability who die at BHNFT from the age 4 years old.
Barnsley Hospital NHS
NHS Foundation Trust
Time Frame
Day of death
Nurse in charge of shift to complete Datix following a death of all patients with diagnosed learning disability.
Learning Disability Nurse to check Lorenzo on a daily basis to identify all learning disability inpatient deaths.
Datix to be sent to Named Nurse Adult Safeguarding and Learning Disability Liaison Nurse to inform of death.
Within 48 hours
Safeguarding Adult Team/Learning Disability Named Nurse to review medical records in order to perform initial LeDeR Review into the death.
Within 48 hours
Safeguarding Adult Team/Learning Disability Named Nurse to inform Matron, Consultant and Patient Safety & Quality Lead in order to provide links and support to the Trust's Mortality Review Process.
Completed within 60 days of death
Safeguarding Adult Team/Learning Disability Named Nurse will:
1. Notify LeDeR via on-line portal or telephone.
2. Safeguarding Adult Team/Learning Disability Named Nurse will consider if a full MDT review is required and inform the Patient Safety Team if a full review is required.
• In the event of a full review, Safeguarding Adult Team/Learning Disability Named Nurse would co-ordinate and lead Multidisciplinary Team Meeting with relevant parties, this would include relatives and carers.
3. Following the review Safeguarding Adult Team/Learning Disability Named Nurse to complete the outcome of the review in the Action Plan.
4. Safeguarding Adult Team/Learning Disability Named Nurse to consider the need for escalation into the Trust's serious incidents procedure and/or safeguarding procedures.
5. Safeguarding Adult Team/Learning Disability Named Nurse would update Datix.
6. Feedback and learning from reviews to be undertaken via the weekly Patient Safety Panel.
7. Ongoing liaison and updates with relevant Trust departments eg. Legal Services, Patient Experience Lead, Childrens Safeguarding Team as appropriate.
8. Once LeDeR full Review is completed the report to be sent to Medical Director and head of patient safety & quality improvement for sign off prior to submission to NHS England. This will mirror the procedure for serious incidents sign off and escalation.
Nurse in charge
Adult Safeguarding Team
(2016_10_20) V1 Learning Disability Shared Drive

Appendix 4

Version	Date	Comments	Author
1			
2			
3			

Review Process Prior to Ratification:

Name of Group/Department/Committee	Date
Learning from Mortality Group	13 May 2020
Clinical Effectiveness Group	